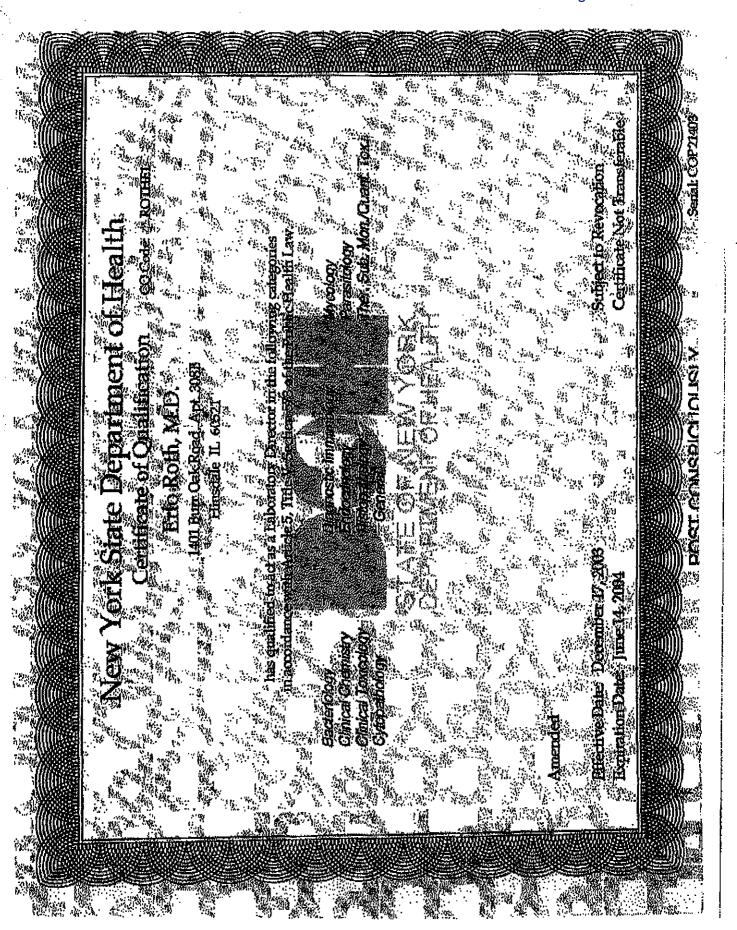
EXHIBIT GG



NEW YORK STATE DEPARTMENT OF HEALTH WADSWORTH CENTER CLINICAL LABORATORY EVALUATION PROGRAM EMPIRE STATE PLAZA, P.O. BOX 509 ALBANY, NEW YORK 12201-0509

(;):

APPLICATION FOR INITIAL PERMIT

	FOR OFFICE USE ONLY Recd.
1	Fee No
İ	PFI:Li-I-I-I Code No. Li-I-I-I-I-I-I
į	GLIA No: LI-LI-LI-LI-LI-LI-LI-LI-LI-LI-LI-LI-LI-L

Laboratory Contact Person to Arra	nge On-Site	inspection:	. Agualas	Dalbke	
Telephone Number: 773-693	-0400	Projec	ted Openi		
GENERAL LABORATORY INFO	PINATION].:": : el		1	
NAME OF LABORATORY: (Please		10/1	o 70)		FEDERAL EMPLOYER ID NO.
<u>เล้าได้เลืองโดการ์เลเอเลาเลาส์เดเ</u> เล้าได้เลียงเลียงการ์เลเอเลเลาส์เดเล					3/8/4/13/1/4/4/0
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CITY, TOWN OR VILLAGE		STATE 山山	ZIP CODI ල්ලාරුණ		THIS LABORATORY [] IS [V] IS NOT A SMALL BUSINESS
LABORATORY TELEPHONE NUMBER (Z/Z/3) LGZ/3 LGZ/LGG FAX NUMBER (Z/Z/3) LGZ/3 LGZ/L/LG	dossado/bks	ee Obiosofemt	COM TU	VS AND HOUR 1880 to 1700 1880 to 1700 1880 to 1700 1880 to 1700	Se to Su to
2. OWNERSHIP INFORMATION				<u>લું મે</u> જે જેલા છે છે.	
A. Type of ownership:1 [Individ. 41 I Gov	udi 2 () Par ernment	tnerehip 3 (v	/ Corporation	on or I Not-F	or-Profit Corporation
8. Name of owner(s) or corporation	i Biliois	SignElsh - Mithic		•	រទី <i>ក្</i> ទែរក <u>ា</u> ក្រដួសសកា
C. Owner/corporation address of pr	ଜ୍ୟୁ		រុកប្រជុំពិរ	<u> </u>	işinintist-işşo
D. List all individuals having direct o Controlling Interest Disclosure State					
3. FACILITY TYPE					
For any facility type indicated with an as York State. York State. I Ambulatory Surgary Center* Community Clinio*. Comprehensive Dutpatient Hensbilitation Facility* I Ancillery Testing Site in Health Care Facility* I Bed State Renal Disease Obtive's Facility* I Health Maintenance Organization*		copy of your N' [] Hospide* [] Hospidal* [] Independe [] Industrial [] Insurance	YS Licensa or ent ete Care Facil entally	Operating Cartif	
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4. OTHER APPROVALS		MAAN AMANDEMENT OF STREET
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MEDICAID NO. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.		
E. OTHER INFORMATION	YES	NG.
is the laboratory negrating Patient Service Centers (Collecting Stations) or Limited Teating Stear		,
If yes, you must complete a separate application for sech. Applications can be obtained by contacting our office (see instructions).	1000	
is the laboratory energing a mobile courier service?		
la laboratory operated rander o management contract?		
If yes, give name of management company and estach a copy of the contract.		
8. LABORATORY PACILITIES	Particular processors of the same particular and the s	
A. Description of the isburatory facility	· <u> </u>	-
Please provide a drawing of inhuratory quarters or a blueprint, if available, and enemor the following questions:		
i, is all fahoretory space contiguous? If no, please indicate other location(s).	V	
2. What is the total approximate square footage of the laboratory work space? Square Fast 3608		:
3. Is the laboratory located within space occupied by any other health service provider? If yes, please explain.		borro.
B. Laboratory equipment	<u></u>	
List and briefly describe the equipment, which is or will be located in the isboratory lo.g., r buths, starilizers, centrifuges, photometers). Use additional sheets if necessary.	nicroscopen, Inci	ulistors, water
Beckman Coulter CX7 Chemistry Analyzer		٠
Drc Vmax Kinetic Microplate Reader		•
DPC Micromix 5 microplate mixer		
DPC Microwath & microplate washer		
bpc. Microlife. 3, microplete pipething station		
Bio Tech Inst: E1404 Microplate Washer		
Hybritech Variable Mate Rutator		
Labline Just. Titer Plate Shaker		
Backman 73-6 Centrifuge		
Precision Incubator		j
Denver Inst Analytical Balance		
Ohais Harvard Trip Balance		

				PFI:
7. Technical Personnel				
List on the englosed "Personnel Commer street employee personnel re	onsolidation Shoat sters or listings p	(DOH-708) the technical provided they are set up in t	personnel working i he same format.	in the laboratory. You
8. Laboratory Directorship				
A. Laboratory Director:				
Title: 1[V] Dr. 2[] Mr. 3[Ms. 4[] Miss 5[] Mrs.	CQ Code:	Or applied for CO? Yes (No ()	Social Security	
First Name: Milan				Middle initial:
Lest Name: Babich		· · · · · · · · · · · · · · · · · · ·		
Home Address - Number and Stroot:	15004 Pleaso	ent Valley Road		
Chy, Town or Village: Woodstock			State: I.	Zip Cade: 60098
Tu to Th to Director Status: 1[] Full-time Dep 2(1/) Farr-tin 3. Other Employment of Director List ell other employers of the director.	gree(s) Held: 1(v) 10	4[] D.V.M. 6[]	3[] D.D.S. Ph.D. 6[] D.S	448
facilities. Provide days of the week en	d hours per day s	erved, and give title or brie	f description of du	tles,
Vame and Address of Institution/Emplo	yer . Ho	urs: From - To	Title/Dutles	
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C. Assistant Directors: Exchaling the director, list below those Quelification and who assume personal and algo and date this application on parameters to indicated on page it.	personnel service reaccoshility for uge 6. Attach ad	g the leboratory as assiste tests performed. All anal ditional sheets if necessar	int directors who holi sten: director(s) inus y. Personal responsi	d Certificatists) of a road the certification bility for categories
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Title: 1() Dr. 2() Mr. 3() Ms. 4() Mise 6() Mrs.	CO Code:	Or appilled? Yes [] No []	Spoid Sepurity N	lumber:
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Last Name:		The state of the s	. <u> </u>	Middle tratlef:
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City, Town or Village:			1587.8.4	
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Last Namo:				
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	s. CATEGORIES OR SUBCATECORIES FOR WHICH YOU Indicate CO. Code for all individuals (director/as	sistant directo	ti tesponsir	nle for each pategory requested.	Attaoh odd	ltional
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10. GERTIFICATION		diameter and
I HAVE RECEIVED AND READ COPIES OF THE FOLLOWING DOCUMENTS:	VES	MC)
Part 19 of 10.NYCRR - Duties and Qualifications of Clinical Laboratory Directors (3/96)		
Port 84 of 10 NYCRR - Health Care Practitional Referrals (1/94)	To the second	
Part 58 of 10 NYCRR - Clinical Laboratories (2/94) and Blood Banks (1988 Ravision under review)	ļ., w	nia mana Bafa
Fart 63 of 10 MYCRR - Aids Testing and the Confidentiality of HIV-Related Information (1/94)	- W	
Part 70 of 10 NYCRR - Regulated Medical Waste (2/83)	y	····
Article 2, Title II-D of the Public Health Law - Health Care Practitioner Referrals (2/95)	- K.	.' -H! Mb nere
Article 6, Title V of the Public Health Law - Cilnical Laboratory and Blood Ganking Services	- te	
Article 5, Title VI of the Public Health Law - Laboratory Business Practices (2/95)		··· • • · · · · · · · · · · · · · · · ·
Laboratory Standards Issued by the Department		برد
I understand that under section 577.1(a) of the Public Health Law the permit of this labor rovoked, suspended, limited, or annulled if any fact is misrapresented in this application on the information in this application must be reported to the Clinical Laboratory Evaluation mediately by the laboratory director(s) or owner. I also understand that additional penaltic apply if I misrapresent, conceal, or fell to disclose facts or information measures.	Change	nay es (b) (s)n

continuing sligibility for said laboratory permit. Further, I understand that offering a false instrument constitutes a crime under the penal law of the State of New York.

I understand that by signing this application form I agree to any investigation made by the Department of Health to verify or confirm the information I have given or any other investigation made by them in connection with my request for this isboratory permit. If adoltional information is requested, I will provide it. Further, I understand that, should this application or my status be investigated at any time, I agree to cooperate in such an investigation.

in signing this application, I hereby certify that the information I have given the Department of Health as a basis for obtaining a laboratory permit is true and correct.

THE \$1,100.00 REGISTRATION AND INSPECTION AND REPERENCE FEE MUST BE INCLUDED WITH THIS APPLICATION. PLEASE ENGLOSE A CHECK MADE PAYABLE TO THE NEW YORK STATE DEPARTMENT OF

Print Name of Assistant Director Print Name of Assistant Director:	Signature of Assistent Director	Date
Print Name of Assistant Director	Signature of Assistant Director	Date
Mildin Bolich M.D. Print Name of Director DAVIO C. FLEISNER Frint Name of Owner	Signature of Owner Signature of Owner	4/6/09 Date 4/8/47 Date

LABORATORY PFI & CODE NUMBERS: NAME AND ADDRESS OF LABORATORY: BIUSOR Laboratories, Inc.
8600 W Catalpa Ave.
Chicago, IL 60656

NEW YORK STATE DEPARTMENT OF HEALTH WADSWORTH CENTER **CLINICAL LABORATORY EVALUATION PROGRAM** EMPIRE STATE PLAZA, P.O. BOX 509 ALBANY, NEW YORK 12201-0509

ONCOLOGY-SERUM AND SOLUBLE TUMOR MARKERS QUESTIONNAIRE

Complete if the laboratory holds or is applying for a permit in this category. Referring to the enclosed instructions indicate the manufacturer, kit and method (RIA, EIA etc.) used for each type of test performed. Processing of your application and mailing of proficiency tosting specimens will be delayed until this questionneire has been received.

Anaiyte	Instrument Code	Reagent Code	Numbers of Samples Analyzed in Last 12 Months
D AFP		5 — — — — — — — — — — — — — — — — — — —	4
□ CEA	<u> </u>	6	7
¥(PSA	MPR	H 7 4	10
o Free PSA	п	12	13
□ CA125	ta	15	16
□ CA15-3			19
□ CA19-9	20	21	22
□ CA27,29	23	24	26
□ NMP22	26	27	28
© Bard BTA	20	30	31
∵⊐ AuraTek	32	53	34
Other*	3	15	D7
	# ***	21	40

lucings	patholog	y/cytology)? No _V Yes If yes, describe.*	\ <u>-</u>
The lab for the p	oratory surrent re	director a esponsibili	and all responsible assistant directors must sign below. les of each peol giant director.	For renewal applications, refer to page 2
Date)	Signature, Laboratory Director	44 GC Gods
late			Signature, Assistant Oirector	42

Are there any other tests your laboratory is currently performing that are used in the diagnosis or management of cancer (do not

Additional responsible assistant director(s) must also agis only from the major of the distribution of the

CO Code

LABORATORY PHI & CODE NUMBER:
NAME AND ADDRESS OF LABORATORY:
Bio Safe Laborahories, Inc.
Bioco W. Catalpa Ave.
Chicago, Il 60656

NEW YORK STATE DEPARTMENT OF HEALTH WADSWORTH CENTER CLINICAL LABORATORY EVALUATION PROGRAM EMPIRE STATE PLAZA, P.O. BOX 509 ALBANY, NEW YORK 12201-0509

DIAGNOSTIC IMMUNOLOGY - DIAGNOSTIC SERVICES QUESTIONNAIRE

Indicate all analytes that you currently test for or wish to apply for below. Referring to the enclosed instructions, enter under column I the code for the test (admirple you will be using under II, enter the code for the test manufacturer, and under III enter the number of tests your laboratory performed in the tast calendary year. Please interest indicated below on donors of human organs andor tissues for transplantation you should apply for the Donor Services categorical and mailing of proficiency testing appointing of your application and mailing of proficiency testing appointments will be delayed until this of

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The laboratory director and all responsible assistant directors must sign below. For renewal applications, refer to page 2 for the current responsibilities of each

Milan Bobich M.D. Print Name or Co Code	Print Name or CO Code
Signature, Laboratory Director	Signature, Assistant Director
4 10 [99	Pate

Additional responsible assistant director(s) must also sign and print name(s) below or use an additional street

Page 10 of

DOH-679a(2398)

New York State Department of Health
Wadsworth Center
Clinical Laboratory Evaluation Program

FACILITY PERSONNEL

LABORATORY:
ADDRESS:
CHY:
STATE:
ZP CODE:

CONSULTANT:

SURVEY DATE(S):

LABORATORY TESTING HOURS:

LABORATORY DIRECTOR:

LABORATORY ASSISTANT DIRECTOR(S):

DOIL-709 Ravised October 1998

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CLINICAL LABORATORY EVALUATION PROGRAM WADSWORTH CENTER NEW YORK STATE DEPARTMENT OF HEALTH EMPIRE STATE PLAZA, PO BOX 509 ALBANY, NEW YORK 12201-0609

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APPLICATION FOR CERTIFICATE OF QUALIFICATION - CLINICAL LABORATORY DIRECTOR/ASSISTANT DIRECTOR

Please read the enclosed Part 19 10NYCRR for a description of certificate of qualification requirements and read and follow the instructions carefully since submission of incomplete or incorrect applications will dalay processing.

NOTE: You must enclose a \$40.00 application fee payment. Your check or money order should be made payable to the New York State Department of Health.

1 TYPE OF APPLICATION: Initial	□ Renewsi	Amendment
2. PERSONAL INFORMATION:	•	• .

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15004 Pleasant Vo	illey Rd.	woodstock	IL	40098
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(Hame) 8/5,338 8955				

3 GRADUATE/PROFESSIONAL EDUCATION: List all medical schools, colleges and universities attended in chronological order whether or not a degree was received. Renewal applicants need only list any education gained since the last application.

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University of Zagreb,	A Property of the Control of the Con		3 div 2		, ,
Medical School Ricky	Croatio	Medicine.		1962	MD.
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List any additional education in the same format on an attached continuation sheet.

4. BOARD CERTIFICATION: Initial applicants must provide a copy of their Board Certificate(s).

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American Board of Pathology	5/6/14
· · · · · · · · · · · · · · · · · · ·	

List any additional board certifications in the same format on an attended continuation sheet.

5. LICENSURE: Physicians and dontiets who are licensed and registered with the New York State Education Department must provide a gopy of their ourrent registration. Applicants not licensed in New York State but licensed in enother state must provide a popy of their current registration in their state of macrica. Unificanced applicants must provide an official copy of their doctoral transcripts.

Are you licensed and currently registered to practice medicine or dentistry in New York State? If Yes No

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Are you liganeed and currently registered to practice medicine or dentistry in any other state? MY 28 LING.

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Mysician + Surgeon	36-43989	TL	1971	7/31/99

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List any additional licensure information in the same format on an attached continuation sheet.

6. POSTDOCTORAL TRAINING & EXPERIENCE: List all positions held in reverse chronological order. Renewal applicants must list all training or experience gained since the last application whether or not their duties have changed.

	1971	/973
alhology		
	1969	1971
	alhology	

List any additional experience in the same format on an attached continuation sheet.

7. CURRENT EMPLOYMENT: All sites of current employment must be listed along with job titles, whether as laboratory director or otherwise, and the name of your director or supervisor.

Name: Addivision in the principle of the investment of the investm	S. Kim, M.D.	athologist	1989 1989
Description of Dutles: Anatomic/Clinical Arthology Microbiology, Chemistry, 215.			
Biosofe Laboratories, Inc. Chicago, IL.		Laboratory Director	3/1999
Description of Duties:		 vikasi .	

List any additional current employment in the same format on an attached continuation sheet.

Applicants are encouraged to include a copy of their current curriculum vitae.

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B. CATEGORIES REGUESTED: Be sure to check off each category you seek to hold on your conflicte. You will not be considered for any category you do not apply for. Renewel and amendment applicants check only additional netegories requested.

•	HEIGHTS GROWN ONLY GROUNDING INSTERNOUS TOGGOSTORY		
QATEGORIES	MD, Liconse, Registration, Reconcy and	Doctoral Degree, Augurery and	
ыступичення в при	ABPICE), ABMM or Experience	ABMM or Experience	
D Blood Banking Collection - Comprehensive	Experience	Excanance	
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X Clinical Chandstry	ABP(CP), ABCC(CC) or Experience	ABCC(CC) or Expellence	
io Gyrogensiles	Expolignoo	Experience	
i) Cyropathalogy	ABPIAPI		
of Diagnostic fruithrotogy	ARP(CP), ABMM, ABMLI or Experience	ABMM, ABME or Expedience	
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O Histocompatibility	Experience	Experience	
ia Histopathology Douglestings Ostmatopathology	Abpiap) Abpiap) Abpiap) of Abpidp)	ABOPIDES only)	
El furminaliamethiath	ASP(CP) or Experience	Expolience	
El Mycobacteriology	ABY(CP), A8MM or Experience	ABMM or Experience	
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Ti Paternity Identity Tosting -RLA Testing Di Paternity/Identity Testing -Diood Genetic Market Testing Di Paternity/Identity Testing -DNA Testing	Exparionos	Exportance	
Ci Titen Bub. Man./Quant. Tox.	ABPICP), ABCCICCI, ABCCITC) or Experience	ABCCICCI, AGCCITC) or Experience	
77 Transfusion Services 1	ABP(SB/TM), ABP(CPI + 6 months Training, ABIM(Ham) + 6 months Training, or Experience		
□ Virology	ABMM or Experience	ABMM or Expellence	

B. CATEGORIES REQUESTED: Be sure to check off oach extenderly you seek to hold on your confliction. You will not be considered for any astronomy you do not apply for. Renewal and amendment applicants check only additional categories requested.

	The approants theoremail additional dategories requested. REQUIREMENTS		
CATEGORIES	MD, Liponse, Registration, Recenny and	Doctoral Degree, Recenny and	
u Bacteriology	ABP(CP), ABMM or Experience ABMM or Experience		
য় Bluod Banking Collection - Comprehensive	Experience	Expansion Expension	
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i) Blood Lead	ABP(CP), ABCC(TC), ABFT or Experience	ABCCITCI.ABFT or Experience	
D Blood pH and Gases	ABP/CP). ABCCICCI or Experience ABCCICCI or Experience		
Cellular immunology - Limited t Cellular immunology - Limited II Cellular immunology - Limited IIB Cellular immunology - Limited III Cellular immunology - Limited III Cellular immunology - Limited IV	Experience Experience		
✓ Glinical Chemistry	ABP(CP), ABCQ(CQ) or Experience	ABCC(CC) or Experience	
D Cytogonetics	Experience	Experience	
C) Cytopathology	ABP(AP)		
😾 Diagnostic immunology	ABP(CP), ABMM, ABMLI or Experience	ABMM, ABMLI of Experience	
□ Drug Anatyals/Qualitative	ARP(GP), ABCC(CG), ABCC(TC), ABFT or	ABCC(CC), ABCC(TC), ABFT or	
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a Crythrecyte Protoporphyrin	ABPICPI, ABCCITC I, ABPT or Experience	ABCUITC), ABFT or Experience	
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C Forensko Toxicology	ARCCITC), ABEY or Experience	ABCCITCI, ABFT of Experience	
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ti Hernatology	ABP(CP), ABIM(Hem) + 8 months Training, or Experience .	Experience :	
17 Histocompatibility	Бхрапелие	Experience	
니 Histopathology 다 Oral Pathology 다 Dermatapathology	ABPIAP) ABPIAP) ABPIAP) or ABPIDP)	A80PIODS only	
□ Immunohematology .	ABP(CP) or Experience	Experience	
□ Mycobacteriology	ABF(CF), ABMM or Experience	ABMM or Experience	
D Mygalogy	ABP(CP), ABMM or Experience	ABMM or Experience	
□ Oncofetal Antigons-Fetal Defect Markers	Ехрегіалов	Exparianou	
♣ Oncology-Sura and Soluble Tumor Markers □ Oncology-Molecular Octaotion	Experience	Exparience	
J Parastrology	ABPICP), A8MM or Experience	ABMM of Experience	
⊇ Paternity/identity Tosting -HLA Tosting ⊇ Paternity/identity Tosting -Blood Genetic Marker Testing ⊇ Peternity/identity Tosting -DNA Testing	Experience	Experience	
Ther. Sub. Mon./Quant, Tox.	ABP(CP), ABCC(CC), ABCC(TC) or Experience	ABCC(CC), ABCC(TC) of Experience	
3 Transfusion Services	ABPIBB/TMI, ABPICP) + 6 months Training, ABIMIHem) + 8 months Training, or Experience		

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ABMM or Expedence

6. Post Doctoral Training and Experience (cont.)

Chicago , IL		Medical Director of Particulogy Dept.	1974	/989
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Describe dulles by specify.				

CERTIFICATION

Have you over had charges of administrative violations of local, state or federal laws, rules and requiations, including, but not limited to, the Public Health Law or related statutes, concerning the provision of health care services or raimbursement for such services sustained against you? Are such Springer currently pending?

☐ Yes ▼ No

If yes, please provide details on a separate sheet and attach to this form.

Have you ever been convioted of any crime, including, but not limited to, any offense related to the furnishing of or billing for clinical laboratory services and medical care, services or supplies, which is considered an offense involving theft or fraud? Are such charges currently pending?

> ☑ No C) Yes

If yes, please provide details on a separate sheat and attach to this form.

I understand that under Section 677.1(a) of the Public Health Law my Certificate of Qualification may Ь. be revoked, suspended, limited or annulled if any fact is misrepresented in this application. Changes in any of the Information in this application must be reported to the Clinical Laboratory Evaluation Program immediately. I also understand that additional penalties may apply if I misrepresent, concest, or fail to disclose facts or information regarding my initial or continuing eligibility for a Certificate of Qualification, including conviction of any crime related to billing for laboratory services, omission or misrepresentation of material facts in applying for professional license, parmit or registration related to the operation of a clinical laboratory or the concesiment of ownership or controlling interest in a clinical laboratory. Further, I understand that offering a faise instrument constitutes a crime under the Panal Law of the State of New York.

I understand that by signing this application form I agree to any investigations made by the Department of Health to verify or confirm the information I have given or any other investigation made by them in connection with my request for this Certificate of Qualification. If additional information is requested, i will provide it. Further, I understand that, should this application or my status be investigated at any time, lagres to cooperate in such an investigation.

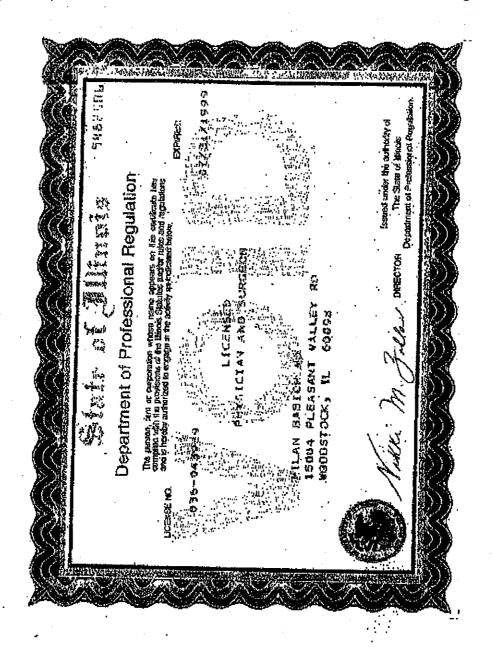
in signing this application, I heraby certify that the information I have given the Department of Health as a basis for obtaining a Certificate of Qualification is true and correct.

Signaturé

The \$ 40.00 application fee must be included with this application.

Submit forms to:

CLINICAL LABORATORY EVALUATION PROGRAM WADSWORTH CENTER NEW YORK STATE DEPARTMENT OF HEALTH EMPIRE STATE PLAZA, PO BOX 509 ALBANY, NEW YORK 12201-0509



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The American Board of Pathology

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